

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11139

Reg. Diat. No. 100

## 1. PLACE OF DEATH:

County Charles  
 City or town Laplace (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs 7 mos.  
 Hospital, institution, or street address where death occurred: —  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Charles County  
 City or town (Rural) La. Plate Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. —  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war —

## 3. (a) FULL NAME

Burton Lee Benson

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Ella V. Benson

7. Birth date of deceased (mo., day, yr.) Jan 24 1867 6.(c) If alive, give age — years

8. AGE: Years 80 Months 10 Days 20 If less than one day — hrs. — min.

9. Birthplace Washington D.C.  
 (Town, county, and state)

10. Usual occupation none

11. Industry or business —

12. Name Thomas R. Benson

13. Birthplace Washington Grove, Md.

14. Maiden name Julia Burton

15. Birthplace Burtonville, Md.

16. Informant Carl H. Beale

Address Laplace, Ind.

17. Removal Date thereof 12-16-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Adrian Chapel

Location East Pleasant, Md.

18. Funeral director W. W. Chambers Co.

Address 517-11th St. S.E.

19. 12-16 19 47 Julia A. Pacey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16 19 47 at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-13 19 47 to 12-16 19 47 and that I last saw him alive on 12-13 19 47

Immediate cause of death Coronary Occlusion

Due to Sen. Arterio Sclerosis

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of Injury — Injured at work? —

23. SIGNATURE E. Beale M.D.

Address Laplace, Md. Date signed 12-16-47

RECEIVED

DEC 22 1947

U.S. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11140

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County Charles  
 City or town La Plata  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 hrs.  
 Hospital, institution, or street address where death occurred:  
Physicians Memorial Hospital  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Charles  
 City or town Waldorf  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Paul H. Bidgood

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

August 8, 1904

## 8. AGE:

Years

Months

Days

If less than one day

43515

hrs.

min.

## 9. Birthplace

(Town, county, and state)

Virginia

## 10. Usual occupation

Carpenter

## 11. Industry or business

## 12. Name

Charles P. Bidgood

## 13. Birthplace

Va -

## 14. Maiden name

Cecilia E. Beachman

## 15. Birthplace

Washington DC.

## 16. Informant

## Address

Mrs Gladys Bidgood  
Waldorf Md.

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

12/261947Julia H. Pugh

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1947 at 4:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 22, 1947 to Dec. 23, 1947and that I last saw him alive on Dec. 22, 1947

Immediate cause of death

Cerebral hemorrhage

## DURATION

14 hrs.

Due to

Unknown

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

James E. MacKaway, M.D.  
La Plata, Md.

M. D. or other

Address

Date signed 12.23.47

RECEIVED

JAN 5 1948

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 11141 106

### 1. PLACE OF DEATH:

County Charles  
City or town Indian Head  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 14 hours  
Hospital, institution, or street address where death occurred:  
170 Road Indian Head  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Charles  
City or town Indian Head  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 170 Road Perry Wright Homes  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

James David Brown

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single

### 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 14<sup>th</sup> 1947 6. (c) If alive, give age... years

8. AGE: Years Months Days If less than one day 14 hrs. min.

9. Birthplace Indian Head, Maryland  
(Town, county, and state)

### 10. Usual occupation

### 11. Industry or business

12. Name Lawrence Vincent Brown  
13. Birthplace Indian Head, Maryland  
14. Maiden name Dorothy Saunders  
15. Birthplace Washington, D.C.

16. Informant Dorothy Brown  
Address Indian Head, Maryland

17. Burial Date thereof Dec 15, 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory St. Chas.  
Location Glenmont, Md.

18. Funeral director Lawrence V. Brown  
Address Indian Head, Md.

19. Dec. 15 19 47 Odey Price  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 19 47 at 7:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 13 19 47 to Dec 14 19 47  
and that I last saw him alive on Dec 13 19 47

Immediate cause of death Asphyxiation

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Percival C. Smith M. D. or other

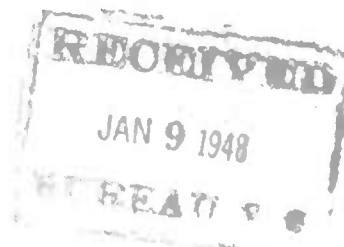
Address Indian Head, Md. Date signed 12-14-47

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11142

Reg. Dist. No. 106

## 1. PLACE OF DEATH:

County CharlesCity or town Pomonkey  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Pomonkey  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Elizabeth C. Campbell.

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

C

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date at deceased (mo., day, yr.) Aug 7, 1946.

## 8. AGE:

Years 1Months 8Days 26

If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Indian Head Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

MOTHER FATHER

## 12. Name

Jas. H. Campbell

## 13. Birthplace

Pomonkey, Md.

## 14. Maiden name

Mary R. Brauner

## 15. Birthplace

Pomonkey Md.

## 16. Informant

Mary R. Brauner.

## Address

Pomonkey Md.

## 17.

(Burial, cremation, or removal, Which?) BurialDate thereof Dec. 6 47.  
(month) (day) (year)

## Cemetery or crematory

St. Charles.

## Location

Geymont Md.

## 18. Funeral director

Henry Perry

## Address

Mason Springs Md

## 19.

12-5  
(Date rec'd by registrar)19 47M. E. Ransome  
Deputy Clerk Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1947 at 4:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on \_\_\_\_\_ to \_\_\_\_\_ to \_\_\_\_\_

Immediate cause of death

No physician in attendance  
prolonged bronch-pneumonia.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Geo. O. Bicknell Md.  
Marbury Md. M. D. or other Dec 4 47  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

JAN 9 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 104

## 1. PLACE OF DEATH:

County CharlesCity or town Tonphinsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Tonphinsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Samuel E. Colbert

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 15, 1860

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

It less than one day

871113

hrs.

min.

9. Birthplace

Newport, Ind.  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Thomas Hanson Collier

13. Birthplace

Tonphinsville, Ind.

14. Maiden name

Ann Dwyer

15. Birthplace

Newport Ind.

16. Informant

Mrs Minnie Brown

Address

Issue Ind.

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Holy Ghost Cemetery

Location

Issue Ind.

18. Funeral director

Address

Waldorf, Ind.

19.

(Date when by registrar)

19

47Whitehouse

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28-1947 at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-27-1947 to 12-28-1947  
and that I last saw him alive on 12-28-1947

Immediate cause of death

Myocardial Infarction

DURATION

2 days

Due to

Griffith4 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

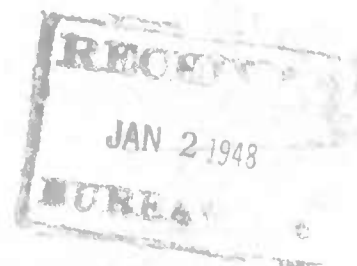
23. SIGNATURE

W. E. Griffith

M. D. or other

Address

WaldorfDate signed 12-28-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11144

Reg. Dist. No. 101

## 1. PLACE OF DEATH:

County Charles  
 City or town Prattville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
—  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Charles  
 City or town Prattville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. —  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war —

## 3. (a) FULL NAME

Emma Irene Franklin

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Harry J. Franklin  
 6. (c) If alive, give age 59 years  
 7. Birth data at deceased (mo., day, yr.) Feb 17, 1893  
 8. AGE: Years 54 Months 2 Days 23 If less than one day hrs. min.  
 9. Birthplace Maryland Point Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife

## 11. Industry or business

MOTHER FATHER  
 12. Name Gregory Bryant  
 13. Birthplace Chesapeake  
 14. Maiden name Mary Hong  
 15. Birthplace Charles Co. Md.  
 16. Informant Elsie Irene Wright  
 Address Bryans Road Md.  
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec 11, 1947  
 (month) (day) (year)  
 Cemetery or crematory Baptist  
 Location Walden Md.  
 16. Funeral director Walden & Ryon  
 Address Walden Md.

## MEDICAL CERTIFICATION 47

20. DATE OF DEATH Dec. 9 1947 at 2 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10 1947 to Dec. 9 1947  
 and that I last saw him alive on Dec 8 1947  
 Immediate cause of death Coronary Artery  
 DURATION  
 Due to Coronary-vascular disease  
 Due to —  
 Other conditions —  
 (Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. —

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistics By —

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

When at injury Injured at work?

23. SIGNATURE George C. Ricknell M.D.Address Maryland Md. Date signed Dec 9, 47

19 Dec 9 1947 Harry J. Franklin  
 (Date rec'd by registrar) (Signature) Registrar

RECEIVED  
DEC 17 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11145

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19.

at

19.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

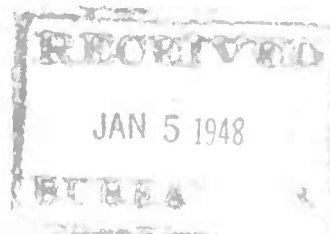
Injured at work?

23. SIGNATURE

M.D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 170c  
 11146  
 Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County CharlesCity or town Rural (Newburg)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

ANNA S. HUFFORD

7. Birth date of

deceased (mo., day, yr.)

MAR. 13, 1900.

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

47

..... hrs.

..... min.

9. Birthplace

Pittsburg, Indiana  
(Town, county, and state)

10. Usual occupation

Cable Driver

11. Industry or business

FATHER

12. Name

RAYMOND HUFFORD

13. Birthplace

PITTSBURG, IND.

MOTHER

14. Maiden name

MAUDE REYNOLDS

15. Birthplace

PITTSBURG, IND.

16. Informant

Address

ANNA S. HUFFORD  
109 ANNE ST. TAKOMA PARK, MD.

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

47

Julia H. Pacey  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

12-31-47, at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to

19.....

and that I last saw the deceased on

19.....

Immediate cause of death

DURATION

Cerebral Hemorrhage

12-31-47

Due to

Trauma to forehead

12-31-47

Due to

Hit by auto

12-31-47

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

12-31-47

Where did injury occur?

Newburg

(City or town)

Ches. Del.  
(County) (State)

Injured at home, farm, industry, public place (where?)

Route 3 - on street

Means of injury

Hit by auto

Injured at work?

no

23. SIGNATURE

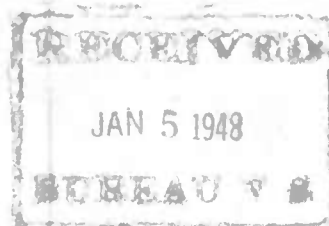
J. E. Edelen

M. D. or other

Address

Lafayette Del.

Date signed 12-31-47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 11147  
184

## 1. PLACE OF DEATH:

County CHARLES  
 City or town WAYSIDE  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 YRS  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County CHARLES  
 City or town WAYSIDE  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. —  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war —

## 3. (a) FULL NAME

AZARIAH JONES

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE COLORED MARRIED6. (b) Name of husband or wife Julia7. Birth date of deceased (mo., day, yr.) 1876 B. (c) If alive, give age years8. AGE: Years 71 Months Days If less than one day hrs. min.9. Birthplace Christfield Md  
(Town, county, and state)10. Usual occupation Cyber man

## 11. Industry or business

12. Name PRESTON JONES13. Birthplace CHRISTFIELD, MD.14. Maiden name LOUISE BLACK15. Birthplace CHRISTFIELD, MD16. Informant Julia JonesAddress Wayside md17. Burial Date thereof 12-4-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Shilo mdLocation Wayside md18. Funeral director Ward & SonsAddress Ward & Sons19. 12/5 19 47 William Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 19 47 at 12:20 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCT. 4 19 47 to DEC 2 19 47 and that I last saw him alive on DEC 1 19 47Immediate cause of death CHR. MYOCARDITIS DURATION 2 YRSDue to —Due to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statitically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Emmet Spencer J. M.D. M. D. or otherAddress Bel Alton md. Date signed 12-3-47

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DEC 8 1947

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11148  
Reg. Dist. No. 100

1. PLACE OF DEATH:  
County... Charles  
City or town... Lapota  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
Phys. Chm. Hosp. Lapota, Md.  
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State... md County... Charles  
City or town... Faulkner  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
Elizabeth T. Miller

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1873 6. (c) If alive, give age..... years

8. AGE: Years 74 Months 3 Days 19 If less than one day..... hrs. .... min.

9. Birthplace... Port Tobacco Ches, Md.  
(Town, county, and state)

10. Usual occupation... Housework

11. Industry or business

FATHER 12. Name... George I. Bateman

13. Birthplace... Ches Co. Md.

MOTHER 14. Maiden name... Elyzabeth Bailey

15. Birthplace... Md.

16. Informant... Mrs Howard Bowie

Address... Faulkner, Md.

17. Burial... Burial Date thereof... 12/15/47

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... St. Ignace

Location... Bel Belton, Md.

18. Funeral director... Huntt & Ryan

Address... Madison, Md.

19. 12-13 19 47 Julia H. Percy

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... 12-12 19 47 at 2:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-5 19 47, to 12-12 19 47 and that I last saw CR alive on 12-12 19 47

Immediate cause of death

Pneumococcus Septicemia DURATION 12-10-47

Due to... Pneumococcus Pneumonia 12-8-47

Due to.....

Due to.....

Other conditions... Pneumococcus Meningitis 12-10-47

Tetralogy of Fallot 12-11-47

(Include pregnancy within 3 months of death)

Major findings of operations... up to 1/2 from ventricles

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... E. E. E. E. M.D. or other

Address... Lapota, Md. Date signed... 12-12-47

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 22 1947  
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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11149  
Reg. Diat. No. 100

## 1. PLACE OF DEATH:

County CharlesCity or town La Plata  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Physicians Memorial HospitalHow long in hospital or institution? 14 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town La Plata  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

SWANN, Raymond Jr.

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Raymond SWANN (Father)

7. Birth date of deceased (mo., day, yr.)

May ? 1946

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

78 mo.

hrs.

min.

9. Birthplace

La Plata, Char. Co. Md.  
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

47

Julia H. Pacey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1947 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-6-47 to 12-7-47and that I last saw him alive on 12-7-47

Immediate cause of death

Shock

DURATION

12-6-47

Due to

2/3 body burned &°12-6-47

Due to

Fall in tub of boiling water12-6-47

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12-6-47Where did injury occur? La Plata Char Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury reluctant of body water Injured at work? no

23. SIGNATURE

E. E. E. M. I.

M. D. or other

Address

La Plata Md.Date signed 12-7-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 15 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1600

## CERTIFICATE OF DEATH

Reg. Dist. No. 1115103.

## 1. PLACE OF DEATH:

County CharlesCity or town Bel Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

James Louis Thompson

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

C

## 6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 12-17-478. AGE: Years Months Days If less than one day 6 hrs. min.9. Birthplace Bel Air, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name John M. Thompson13. Birthplace Frederick14. Maiden name Mary E. Buick15. Birthplace Waldorf16. Informant John M. ThompsonAddress Frederick, Md.17. Burial Date thereof 12-18-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Thomas ManorLocation Bel Air, Md.18. Funeral director John M. ThompsonAddress Bel Air, Md.19. 12-18-47 Mary E. Buick  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Charles

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17-47 1947 at 10 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 10 19 and that I last saw him alive on 19

Immediate cause of death

Suffocation  
Due to Aspiration of vomited  
Due to Food

## DURATION

12-18-47  
12-17-47

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or otherAddress Bel Air, Md. Date signed 12-18-47

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DEC 22 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County... **CHARLES**City or town... **BEL ALTON**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... **MD** County... **CHARLES**City or town... **BEL ALTON**  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

**MARY ROSS WATTS**

## 3.(b) Social Security Number

4. Sex

**FEMALE**

5. Color or race

**COL**

6.(a) Single, married, widowed, or divorced

**WIDOWED**

6.(b) Name of husband or wife

**Charles Watto**

7. Birth date of deceased (mo., day, yr.)

**Sept. 18 55**

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

**92****3****?****hrs.****min.**

9. Birthplace

**Chas. co. md.**  
(Town, county, and state)

10. Usual occupation

**House work**

11. Industry or business

FATHER

12. Name

**James Ross**

13. Birthplace

**Chas co. md.**

MOTHER

14. Maiden name

**unknown**

15. Birthplace

16. Informant

Address

**Arthur M. Ross**  
**Indian Head, md.**

17.

(Burial, cremation, or removal, Which?)

Date thereof

**12/26/47**  
(month) (day) (year)

Cemetery or crematory

**Mt. Rest**

Location

**La Plata md.**

18. Funeral director

Address

**Watts & Ryan**  
**Waldorf, md.**

19.

**12-26**  
(Date rec'd by registrar)

19.

**47****Julius H. Vasary**  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **DECEMBER 22-47** at **1:30 P.** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**Nov 24** 19**47** to **DEC 22-47**and that I last saw him alive on **DEC 18-47** 19**47**

Immediate cause of death

**CHR MYOCARDITIS**

DURATION

**5 YRS**

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

**Emmet Spencer J. M.D.**  
M. D. or otherAddress **BEL ALTON md.** Date signed **12-23-47**

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